

ATTACHMENT 3

Sample CMS 1500 claim form for Community Care Organizations

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																									
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">PICA</div> <div style="margin-left: 10px;"> <div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">(Medicare #)</div> <div style="border: 1px solid black; padding: 2px;">M</div> </div> </div> <div> 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A. </div> </div> </div> <div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">(Medicaid #)</div> <div style="border: 1px solid black; padding: 2px;">Sponsor's SSN</div> </div> </div> <div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">(VA File #)</div> <div style="border: 1px solid black; padding: 2px;">CHAMPVA</div> </div> </div> <div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">GROUP HEALTH PLAN (SSN or ID)</div> <div style="border: 1px solid black; padding: 2px;">FECA BLK LUNG (SSN)</div> </div> </div> <div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px;">OTHER (ID)</div> </div> </div> </div> </div> <div> 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890 </div> </div>																																																																																																																																																																																																																									
5. PATIENT'S ADDRESS (No., Street) 609 Willow St				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 																																																																																																																																																																																																																			
CITY Anytown		STATE WI		CITY 		STATE 																																																																																																																																																																																																																			
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		ZIP CODE 		TELEPHONE (INCLUDE AREA CODE) 																																																																																																																																																																																																																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-D				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 																																																																																																																																																																																																																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER 				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME 																																																																																																																																																																																																																			
c. EMPLOYER'S NAME OR SCHOOL NAME 				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME 																																																																																																																																																																																																																			
d. INSURANCE PLAN NAME OR PROGRAM NAME 				10d. RESERVED FOR LOCAL USE 		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																																																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																																																																																									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																																																									
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 				17a. I.D. NUMBER OF REFERRING PHYSICIAN 		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																			
19. RESERVED FOR LOCAL USE 				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES 		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V68.9 3. _____ 4. _____																																																																																																																																																																																																																			
22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																																																																																																																																																																																																									
23. PRIOR AUTHORIZATION NUMBER _____																																																																																																																																																																																																																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4">24. DATE(S) OF SERVICE</th> <th colspan="2">25. PLACE OF SERVICE</th> <th colspan="2">26. TYPE OF SERVICE</th> <th colspan="2">27. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">28. DIAGNOSIS CODE</th> <th colspan="2">29. \$ CHARGES</th> <th colspan="2">30. DAYS OR UNITS</th> <th colspan="2">31. EPSDT Family Plan</th> <th colspan="2">32. EMG</th> <th colspan="2">33. COB</th> <th colspan="2">34. RESERVED FOR LOCAL USE</th> </tr> <tr> <th>From</th> <th>To</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>CPT/HCPCS</th> <th>MODIFIER</th> <th>CODE</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>01</td> <td>01</td> <td>04</td> <td>01</td> <td>31</td> <td>04</td> <td>88</td> <td></td> <td>G9002</td> <td></td> <td>1</td> <td>XXX</td> <td>XX</td> <td>31</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										24. DATE(S) OF SERVICE				25. PLACE OF SERVICE		26. TYPE OF SERVICE		27. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		28. DIAGNOSIS CODE		29. \$ CHARGES		30. DAYS OR UNITS		31. EPSDT Family Plan		32. EMG		33. COB		34. RESERVED FOR LOCAL USE		From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER	CODE													01	01	04	01	31	04	88		G9002		1	XXX	XX	31																																																																																																																																																			
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25. FEDERAL TAX I.D. NUMBER 				26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ 0 00		30. BALANCE DUE \$ XXX XX		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J.M. Williams MM/DD/YY																																																																																																																																																																																																											
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555		34. PIN# 		35. GRP# 		36. 87654321																																																																																																																																																																																																															

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM HCPC-1500, APPROVED OMB-0720-0001 (CHAMPUS)